

Women's Health *REPORT*

A QUARTERLY PUBLICATION OF WOMEN'S HEALTH DIETETIC PRACTICE GROUP

FOOD SENSITIVITIES AND THE LEAP DIET By Katherine S. Kendall, MS, RD, LD, CLT

Nutritionist, Certified LEAP Therapist and Rebecca Bitzer MS, RD

Women's Health and Food Sensitivities

Food sensitivities are commonly overlooked in the treatment of many chronic health problems. Research conducted over the past 15 years shows a strong link between food sensitivities and several health conditions which are more prevalent among women. As dietitians we are uniquely positioned to bring much needed relief to women suffering from these conditions. Panel-type blood testing for food sensitivities is now available which can identify reactive foods, providing the basis for a patient-specific elimination diet, and, much of the time, bringing prompt symptom relief. In this article the reader will read an overview of adverse food reactions, followed by a discussion of the link between food sensitivities and several women's health conditions and, learn the details of food testing now available to detect these sensitivities and of study results found using such testing.

Women suffer from migraine, diarrhea-predominant irritable bowel syndrome (IBS-D), and fibromyalgia at disproportionately higher numbers than men (1). These conditions can lead to missed days of work, low productivity and overall lower quality of life. Patients spend untold financial resources each year trying to reduce the effects of these debilitating conditions, often without significant improvement in symptoms. Prescription medications can be costly, may have undesirable side effects, and may never get at the causes of these conditions.

Information showing the connection that scientists have identified between these chronic women's health conditions and food sensitivities will be presented later in this article. First we give a brief overview of adverse food reactions, and some of the dynamics involved.

between 1-2 % of the adult population and is characterized by immediate reactions leading to such symptoms as skin rashes, diarrhea and wheezing. Some common Type 1 food allergens are peanuts and shellfish. Immunoglobulin E (IgE) is the type of mediator controlling this type of reaction in the body.

Type 3 and Type 4 delayed food hypersensitivity is characterized by reactions which may begin shortly after eating but may also take up to 72 hours to manifest in the patient. Symptoms associated with these types of hypersensitivities include diarrhea, hives, eczema, excess mucus production, migraine, joint pain, muscle pain, fatigue, and general malaise. Type 3 food hypersensitivity is mediated largely by IgG, whereas Type 4 is mediated by T-cells.

Chemicals involved in these delayed food hypersensitivity reactions are numerous but include cytokines and leukotrienes which generate pro-inflammatory and proalgesic effects in the body. These chemicals are released by leukocytes (white blood cells) in the blood. The Type3/Type 4 food reactions resulting in the release of these chemicals can be globally referred to as non-IgE mediated food reactions. Some sources estimate that the prevalence of non-IgE mediated food reactions in the population is 30-40% (3).

Adverse food reactions not directly involving the immune system are often termed "food intolerances". An example of food intolerance is lactose intolerance caused by a lack of the enzyme lactase. Fructose malabsorption is another type of food intolerance. Symptoms associated with food intolerances include bloating, gas and diarrhea.

Celiac disease does involve the immune system but is neither a food sensitivity nor a Type 1 food allergy. In the case of celiac disease, after exposure to gluten, the body mounts an attack on the body itself rather than the food substance (gluten). Common symptoms include diarrhea, gas and bloating.

There are many types of adverse food reactions and their corresponding symptoms. However, for practitioners in women's health, special attention to Type 3/Type 4 delayed food hypersensitivities is warranted due to the growing body of evidence linking them with migraine, IBS-D and fibromyalgia.

The Connection between Food Sensitivities and Migraine, IBS-D, and Fibromyalgia

As noted earlier, migraine, IBS-D, and fibromyalgia affect women more often than men. Research conducted within the last 15 to 20 years has linked these conditions to food sensitivities. In the late 1990s,

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Adverse Food Reactions

Basically, there are two types of adverse food reactions: those mediated by the immune system and those that are not. Of those mediated by the immune system, there are fundamentally two subtypes: Type 1 food hypersensitivity and Type 3/Type 4 delayed food hypersensitivity.

Type 1 food hypersensitivity (commonly referred to as food allergy) affects

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whdpgchair@gmail.com

Communications Chair

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whdpgcommunications@gmail.com

Publications Editor

Olivia Eisner, MPH, RD, IBCLC
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from the chair Denise Andersen, MS, RD, LD, CLC

This is an exciting time to get involved with the Women's Health Dietetic Practice Group and the ADA, as we offer many networking opportunities and the chance for collaboration with other like-minded organizations.

For instance, our DPG was instrumental in working with the Institute of Medicine to update the IOM guidelines for weight gain during pregnancy. In our most recent teleseminar, entitled "2009 IOM Weight Gain Guidelines" Elizabeth M. Ward, MS, RD updated our members about the newest guidelines that focus on women's preconception weight and ensuring appropriate weight gain during pregnancy. You can find the recorded session and powerpoint of the presentation on our web site: <http://womenshealthdpg.org>. As a member benefit, our DPG has offered two other teleseminars over the past year. Not only do the sessions provide free continuing education credits on various women's health topics, they also afford members the chance to pose questions directly to the presenters.

As you may have seen on the WH DPG member listserv, Jeanne Blankenship, MS, RD shared the United States Breastfeeding Committee Member Report (If you missed it, you can find it reprinted in this newsletter). Other exciting breastfeeding advocacy news includes publication of ADA's updated "Position of the American Dietetic Association: promoting and supporting breastfeeding," published in November 2009. This paper reinforced ADA's position that breastfeeding is the preferred method of infant feeding (J AM Diet Assoc. 2009 Dec; 109:(12) 1979) and can be found in the Evidence Analysis Library.

We are continuing to partner with other DPG's for a networking event that will take place at the Food & Nutrition Conference & Expo in Boston next November. The event will provide an opportunity to meet other members of the WH DPG and to discuss future endeavors. In the meantime, ADA advocates collaboration with other member organizations that are interested in working together to support the "Child Nutrition Act." If you're interested in these initiatives or in enhancing your professional growth, we have numerous opportunities for involvement in the WH DPG. Please contact me at any time at whdpgchair@gmail.com

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from the editor Olivia Eisner, MPH, RD, IBCLC

Named as a major women's health issue by the National Institutes of Health, autoimmune diseases are finally beginning to get the attention they deserve. It is widely known that women suffer disproportionately from autoimmune disease. Taken altogether; women show 3 times the incidence as men. With more than 80 types of autoimmune diseases and a dizzyingly vast array of symptoms that often tend to be vague, intermittent and difficult to detail, practitioners are often in the dark when it comes to diagnosing these conditions, let alone offering patients viable treatment options.

While much is left to be learned about the vast (and expanding) arena of autoimmune disease, what we do know is their effect on the lives of those who suffer from them can be devastating. Based on the fact that autoimmune diseases present predominantly in women and most often during the childbearing years, understanding alternative nutritional treatments is a must for dietitians.

In this issue, we take a look at a couple of dietetic interventions for autoimmune disease. Kelly Morrow, MS, RD, Assistant Professor at Bastyr University in Washington shares her knowledge of the Swank Diet and it's use in patients with multiple sclerosis, while Katherine S. Kendall, MS, RD, LD, CLT and Rebecca Bitzer MS, RD discuss the LEAP diet in detail as a way of handling food sensitivities. In addition, Kathleen Pellechia, RD brings us the latest in research on a variety of autoimmune disorders.

If you are interested in learning more about a specific topic or submitting your own article to the Women's Health Report, we want to hear you from you! Please drop us a line at whdpgcommunications@gmail.com or whdpgpublications@gmail.com!

in a study conducted on IBS-D patients, scientists found elevated levels of pro-inflammatory mediators upon exposure of the upper gut to various foods. These elevated levels were found along with symptoms of IBS while, at the same time, no circulating IgE antibodies specific to the provoking foods were found (2). In other words, this study and several others like it, clearly demonstrate an adverse food reaction causing elevated levels of pro-inflammatory substances without any IgE (Type 1) food allergy causation—thus the conclusion: Type 3 and Type 4 food hypersensitivity is a contributing factor in IBS-D.

Pro-inflammatory and proalgesic mediators such as cytokines and leukotrienes are elevated not only in IBS but also in migraine, fibromyalgia and arthritis (3). In recent years, dietitians have learned of the role inflammation in the body plays in the development of various disease states. Knowing that Type 3 and Type 4 delayed food hypersensitivities contribute to the inflammation “load” in the body, we can see the added benefit that elimination of offending foods can bring in these cases. Some doctors are now recommending food sensitivity testing on all their patients with diabetes to reduce inflammation and improve health outcomes.

Mediator Release Testing for Food Sensitivities and Patient-Specific Elimination Diets

Having determined a strong link between food sensitivity and these disease states, the next step becomes clear. Remove the offending foods for symptom relief. In fact, one recent study demonstrated that once the foods are eliminated from the diet, patients experienced significant reduction in symptoms associated with IBS-D, migraines, fibromyalgia, and arthritis (4). A scored symptom survey used in this study showed a decrease in scores after the Lifestyle Eating and Performance (LEAP) diet of 67.8% for IBS-D patients, 73% for migraine patients and 46% for those with fibromyalgia. In another study, IBS-D patients reported marked improvements in their gastrointestinal symptoms (67% decrease in symptom scores), decreased systemic symptoms, and an overall increase in their feeling of well-being (5). In most cases, relief from symptoms occurs within days, and in other cases, particularly in the case of fibromyalgia, the relief may take several weeks.

Standard “avoidance diets” that make guesses as to which foods may be offensive to a given individual are not as clinically effective as patient-specific elimination diets based on mediator release testing. Food sensitivities are patient-specific, dose-dependent and also labile. A food may cause symptoms at one time for a given patient but not another. Determining which foods are provoking symptoms by traditional means of reviewing food and symptom records can be extremely difficult if not impossible. The fact that food sensitivities can manifest up to 72 hours after a food is consumed is also a complicating factor.

A new era in the management of food sensitivities began about 10 years ago when Mediator Release Testing (MRT) was developed by Signet Diagnostics Incorporated. Mediator Release Testing is an in vitro assay blood test identifying non-IgE immune-mediated reactions to foods and chemicals, i.e. food sensitivities. The assay precisely measures changes to the liquid/solids ratio of a blood sample after whole blood has been incubated with an individual

food, additive, or chemical. The basis for the analysis of liquid to solids change is the fact that, as leukocytes release mediators, the cells burst and cells/solids diminish. The MRT is not limited to only Type 3 reactions such as in IgG type blood testing. MRT detects the outcome of virtually all non-IgE mediated hypersensitivities including both Type 3 and Type 4 hypersensitivity.

Patients can have up to 150 foods and chemicals tested by submitting a blood sample to the proprietary lab for analysis. Results are then generated in an email and hard copy format with supporting documentation to aid the patient and dietitian in following the oligo-antigenic diet referred to by Signet as the LEAP diet. See Figure 1. The results are presented in bar graph and table format. The bars in the graph are color coded according to reactivity. Non-reactive foods are coded green, moderately reactive foods yellow and highly reactive foods, red.

On the following page is a table showing a phased introduction schedule beginning with lowest reactive “safe” foods to higher reactive “safe” or green foods is shown in Figure 2. A food/symptom record can be very useful as the foods are re-introduced into the diet.

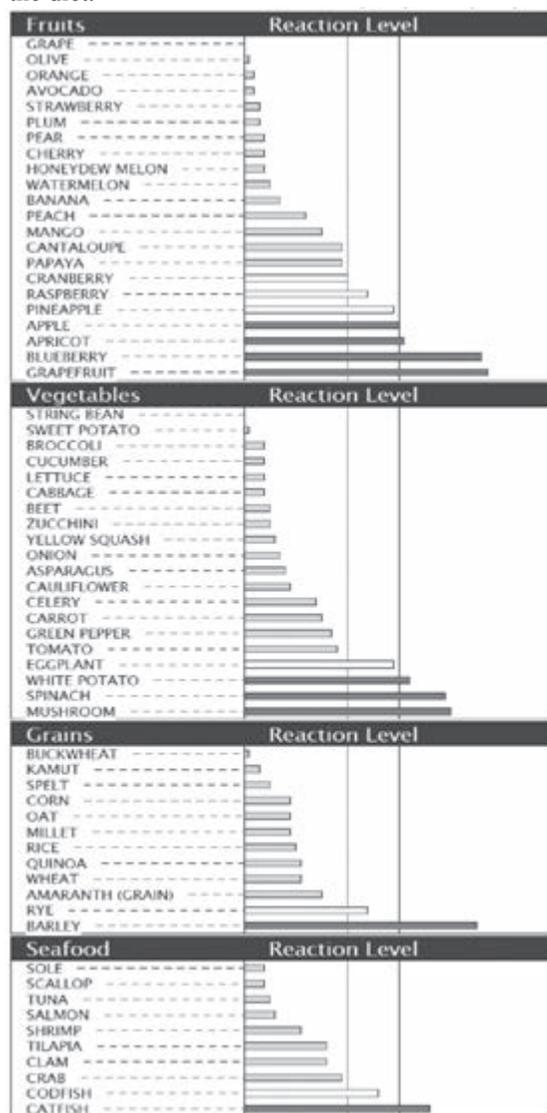


Figure 1

Continued on page 4

Figure 2

Phase 1 of the diet begins with 20-25 of the least reactive foods and is designed to bring levels of pro-inflammatory and proalgesic chemicals to a minimum and hence, relief from symptoms, as quickly as possible. This is the strictest phase of the diet and often is associated with a worsening of symptoms or a general feeling of malaise and irritability followed by a dramatic improvement in overall symptoms, usually within the first week.

After symptoms have noticeably improved, usually within the first 7 to 10 days, then Phase 2 begins with the addition of one new “safe” food each day. The patient is asked to keep a food and symptom diary to track any symptoms which may recur during this time. If a symptom recurs, the patient is advised to “remove” the last 3 foods added and try them again at a later time and to continue to add in other “safe” foods.

Log in to www.womenshealthdpg.org to see an example of a rotation diet.

After a period of about 6 weeks, the patient is then put on a rotation diet to prevent any new food sensitivities from developing. The rotation diet consists of all safe foods eaten once in a 3 day period.

The dietitian and patient work together as a team to ensure success with this process. At the onset, the dietitian plays a key role in bringing the knowledge of the testing and its benefits to the patient. Once the patient has the testing done and has results in hand, a dietitian skilled in food sensitivities and having some mastery in the knowledge of foods and substitutions/alternative cooking methods is critical. Signet does offer special training for dietitians interested in becoming certified LEAP Therapists (CLT), but it is not required to have this certification to offer MRT to clients.

Food sensitivity testing by MRT and the resulting patient-specific diet (LEAP) provide the dietitian critical information which has previously been lacking. Rather than guessing which foods may be causing symptoms, we can now accurately determine trigger foods, plan healthy diets which will bring symptom relief and reduce levels of inflammatory chemicals in the body. Dietitians working in the area of women’s health will most likely find the MRT testing to be one of their most useful tools. This is truly an exciting development in the field of dietetics!

References

- Collins JG. Prevalence of selected chronic conditions, 1979–1981. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1986. (Vital and health statistics; series 10, no. 155).
- Bengtsson U, Nilsson-Balknas U, Hanson LA, Ahlstedt S. Double Blind, Placebo Controlled Food Reactions Do Not Correlate to IgE Allergy in the Diagnosis of Staple Food Related Gastrointestinal Symptoms. *Gut*, 1996 Jul; 39(1): 130-5.
- Madsen C. Prevalence of Food Allergy: An Overview. *Proceedings of the Nutrition Society* (2005), 64. 413-417.
- Patenaude J, Bright D. Clinical Improvement of IBS, Migraine, Fibromyalgia and Arthritides Using Elimination Diets Based on Mediator Release Blood Testing. *J. Am Diet Assoc.* 2009; 109(suppl 3):A-32.
- Williams FH. Use of the LEAP Mediator Release Test To Identify Non-IgE Mediated Immunologic Food Reactions That Trigger Diarrhea Predominant IBS Symptoms Results in Marked Improvement of Symptoms Through Use of An Elimination Diet. Presentation at American College of Gastroenterology, Annual Scientific Educational Meeting, Orlando, Florida, November 2004.

LEAP ImmunoCalm Diet Program – Food Reintroduction Schedule					
	Patient name: SAMPLE PATIENT		Physician: WELLNESS, MARK MD		Identifier: S7000-0
	Phase 1 DAYS 1 – 7		Phase 2 DAYS 8 – 12		Test date: 04/20/2001
	Phase 3 DAYS 13 – 17		Phase 4 DAYS 18 – 22		Phase 5 DAYS 23 – 27
Proteins					
	EGG LENTIL LAMB SCALLOP	SOLE BEEF TUNA SALMON	SHRIMP TURKEY CHICKEN SOYBEAN	CLAM TILAPIA GARBANZO BEAN PORK	CRAB
Starches					
	BUCKWHEAT SWEET POTATO KAMUT	SPELT CORN MILLET	OAT RICE QUINOA	WHEAT TAPIOCA AMARANTH (GRAIN)	
Vegetables					
	STRING BEAN BROCCOLI CABBAGE CUCUMBER	LETTUCE BEET ZUCCHINI YELLOW SQUASH	ONION ASPARAGUS CAULIFLOWER GREEN PEA	CELERY CARROT GREEN PEPPER TOMATO	
Fruits					
	GRAPE OLIVE AVOCADO	ORANGE PLUM STRAWBERRY	CHERRY HONEYDEW MELON PEAR	WATERMELON BANANA PEACH	MANGO CANTALOUPE PAPAYA
Dairy / Miscellaneous					
	WHEY COCOA	CHEDDAR CHEESE AMERICAN CHEESE	YOGURT GOAT'S MILK	COFFEE	
Nuts / Seeds / Oils					
	OLIVE ALMOND SUNFLOWER SEED	CORN HAZELNUT PECAN	SOYBEAN PISTACHIO SESAME	WALNUT CASHEW	
Flavor Enhancers					
	MAPLE BLACK PEPPER CAROB GINGER LEEK	VANILLA CINNAMON CANE SUGAR COCONUT HONEY	DILL CAYENNE PEPPER MINT PAPRIKA TURMERIC	PARSLEY LEMON OREGANO BASIL SESAME	MUSTARD

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NUTRITION INTERVENTIONS FOR MULTIPLE SCLEROSIS

By Kelly Morrow, MS, RD Assistant Professor, Bastyr University, Kenmore, WA

Multiple Sclerosis (MS) is an autoimmune disorder of unknown etiology characterized by the destruction of the myelin sheath surrounding nerves of the central nervous system (CNS). In the United States, more than 400,000 people are affected with up to 200 new diagnoses each week (1). It is more common in women than men and in those with first degree relatives with MS (1). The most common age range for diagnosis is 20 – 50 years of age. The progression can be relapsing and remitting (RRMS) and/or chronic and degenerative with a wide variety of clinical symptoms. Symptoms range from fatigue, dizziness, and numbness to problems with balance, coordination, cognition, vision and swallowing (1).

Complementary and Alternative Medicine (CAM)

It is estimated that 50 – 75% of people with MS utilize some sort of CAM therapy. The most common alternative therapies used in this country for MS are supplementation with omega -3 and omega-6 fatty acids, vitamins, minerals and antioxidants, as well as allergen free diets (esp. gluten and dairy) (2). Because CAM use is so prevalent, it is important that dietitians take a detailed history to properly assess CAM use and potential interactions with pharmaceutical medications.

Current standard of treatment mainly centers around pharmaceutical management of MS. Below is a list of the most common medications and their most common side effects and drug nutrient interactions (DNI's) (3,4,5).

Medication	Action	Side effects / DNI's
Interferon beta 1a and beta 1b	Reduces number and severity of exacerbations	May cause anorexia, weight loss, dry mouth, taste changes, abdominal pain, nausea, vomiting, diarrhea. May increase serum glucose, cause bone marrow suppression and affect the function of the liver, kidneys and bones. Caution with supplements that thin the blood and those that have immune modulating effects.
Copaxone	Stimulates myelin basic protein	May cause fever, chills, dizziness, diarrhea, tachycardia, increased urinary frequency and sores in the mouth. Most people report significant pain at the injection site.
Novantrone	Antineoplastic suppresses T cells, B cells and Macrophages	Need for increased fluids due to increased uric acid excretion. May cause stomatitis, mucositis, nausea, vomiting, diarrhea, bone marrow suppression, elevated serum glucose, impairments in liver and kidney function. Caution with supplements that thin the blood and those that have immune modulating effects.
Tysabri	Monoclonal Antibody	May cause low blood pressure, dizziness, hives, chest pain, nausea, chills and difficulty breathing.
Glucocorticoids	Used for acute exacerbations	May increase appetite, weight, blood sugar, blood pressure and triglycerides. Increases need for calcium, protein, vitamin D, zinc, vitamins A and C.

Dietary factors may play a part in the progression of MS. It is therefore the challenge of the dietitian to determine which interventions may have the most benefit. A recent Cochrane Review on the subject revealed that few studies to date have met their strict inclusion criteria for evaluation. The outstanding conclusion was that more research needs to be done to assess the effectiveness of diets for MS (5). Results are often difficult to assess due to study differences involving disease subtype and disability scores. Multiple observational, cohort, and small scale intervention trials demonstrate a variety of potential benefits as outlined below.

Swank Diet

First introduced by neurologist Roy Swank MD, PhD in 1948, the Swank Diet is the longest studied dietary intervention for MS. Swank was one of the first to propose that MS rates appear to be higher in cultures that consume higher levels of saturated fat (meat and milk) and lower in those that consume more polyunsaturated fats (plants and fish). His findings have been supported by others (6). Although discredited by some because of study design and data collection methods, results of the Swank Diet published after 34 years and again after 45 years show that the 71 people (out of 144) who strictly followed the dietary guidelines had a slower progression of the disease and longer survival (7,8). The basic diet outline is as follows (9):

1. Saturated fat should not exceed 15 grams per day.
2. Unsaturated fat (oils) should be kept to 20-50 grams per day.
3. No red meat for the first year. After the first year, 3 oz. of red meat is allowed once per week.
4. Dairy products must contain 1% or less total fat.
5. No processed foods containing saturated fat.
6. Cod liver oil (1 tsp. or equivalent capsules) and a multi-vitamin and mineral supplement are recommended daily.

Vitamin D

The relationship between low serum 1, 25 OH vitamin D3 and risk for MS has been hypothesized via multiple epidemiological studies (10). Multiple studies on human subjects with MS demonstrate lower circulating vitamin D levels than controls and lower levels during a relapse (10,11). Additionally, it was found that Myelin Peptide Specific T cell lines were inhibited by vitamin D. (11). Although the relationship between vitamin D and MS appears to have significant clinical relevance, there is a lack of data on a therapeutic intervention standard.

Polyunsaturated Fatty Acid's (PUFA) and Antioxidants

Immune mediated oxidative stress and inflammation have been suggested to be a contributing factor in the pathogenesis of MS including demyelination and axonal damage (12). Several studies have described alterations in metabolism of long chain PUFA with subsequent lower levels of DHA, EPA and GLA in the adipose tissue and red blood cells of patients with MS (12). Several studies have described alterations in metabolism of long chain PUFA with subsequent lower levels of DHA, EPA and GLA in the adipose tissue and red blood cells of patients with MS (12).

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Mai et al. demonstrated that glutathione peroxidase activity increased fivefold in patients with MS when supplemented with 6 mg sodium selenite, 2 g vitamin C and 480 mg vitamin E over a 5-week period (14). In one study, 312 patients with MS were given either 2.9 g EPA/DHA or olive oil as the control along with vitamin E and dietary advice to reduce intake of animal fats. After two years, there was no significant difference between the groups although there was a trend toward greater reduction in symptoms and exacerbations with the fish oil group (15). In 2000, Nordvik et al. studied 16 newly diagnosed RRMS patients and intervened using 400 mg EPA, 500 mg DHA, a multivitamin including vitamins E and C, and dietary interventions to increase fish consumption and reduce saturated fat. After two years, the number of MS exacerbations on the expanded disability status scale (EDSS) decreased significantly (16).

Celiac Disease and Autoimmunity

Evidence of a relationship between celiac disease, intestinal barrier function and autoimmune disease is mounting (17). It is suggested that the autoimmune process may be halted by re-establishing intestinal barrier function through the removal of offending food antigens and re-inoculation with probiotics (17). Although a recent study of 217 patients with MS and 200 controls found no correlation between MS and celiac disease, it still may be appropriate to rule out celiac disease in patients with MS given that the prevalence of celiac in the general population is considered to be 1/133 people (18,19).

Summary of Recommendations

Although data from large scale intervention trials have not clearly demonstrated significant clinical benefit for slowing the progression of MS through dietary measures, the nutritional interventions were not shown to cause toxicity or harm. Because MS is a complex condition with multiple genetic and environmental influences, it would seem plausible that a multi-pronged approach to treatment would perhaps be more effective than single approach interventions represented in many randomized controlled studies. There is also evidence that interventions may have added benefit if started early on in the progression of the disease. Until more research is done, a common sense approach would include food derived bioactive plant compounds and antioxidants, balanced intake of PUFA's, limited saturated fats (15 grams or less per day), multivitamin supplementation, and vitamin D intake to prevent clinical deficiency as evidenced by serum levels. Diagnostic testing to rule out celiac disease may also be warranted.

References

1. National MS Society. <http://www.nationalmssociety.org/about-multiple-sclerosis/index.aspx>. Accessed February 18th 2010
2. Farinotti M, Simi S, Di Pietrantonj C, McDowell N et al. Dietary Interventions for Multiple Sclerosis (Review). Cochrane Database Systematic Review. 2007 Jan 24;(1):CD004192
3. Pronsky. Food Medication Interactions. Birchrunville, PA: Self Published

4. Copaxone Website. <http://www.copaxone.com/> Accessed February 25, 2010
5. Tysabri Website. <http://www.tysabri.com/> Accessed February 25, 2010
6. Malosse D, Perron H, Sasco A, Seigneurin JM. Correlation between milk and dairy product consumption and multiple sclerosis prevalence: an ecological approach. *Neuroepidemiology*. 1992;11:304-312
7. Swank RL, Dugan BB. Effect of low saturated fat diet in early and late cases of multiple sclerosis. *Lancet*. 1990 July;336(8706): 37-39
8. Swank RL, Goodwin J. Review of MS patient survival on a Swank low saturated fat diet. *Nutrition*. 2003 Feb; 19(2):161-162
9. Swank MS Foundation. <http://www.swankmsdiet.org>. Accessed February 19, 2010
10. Pierrot-Deseilligny. Clinical implications of a possible role of vitamin D in multiple sclerosis. *Journal of Neurology*. 2009;256:1468 – 1479
11. Correale J, Ysraelit MC, Gaitan MI. Immunomodulatory effects of Vitamin D in Multiple Sclerosis. *Brain*. 2009;132(5): 1146-1160
12. van Meeteren ME, Teunissen CE, Dijkstra CD, van Tol EAF. Antioxidants and polyunsaturated fatty acids in multiple sclerosis. *European Journal of Clinical Nutrition*. 2005;59: 1347-1361
13. Besler HT, Comoglu S, Okcu Z. Serum levels of antioxidant vitamins and lipid peroxidation in multiple sclerosis. *Nutr. Neurosci*. 2002;5: 215-220
14. Mai J, Sorensen PS, Hansen JC. High dose antioxidant supplementation to MS patients. Effects on glutathione peroxidase, clinical safety and absorption of selenium. *Biol Trace Elem Res*. 1990 Feb; 24(2):109-117
15. Bates D, Cartledge NEF, French, JM, Jackson MJ, et. al. A double blind controlled trial of long chain n-3 polyunsaturated fatty acids in the treatment of multiple sclerosis. *Journal of Neurology, Neurosurgery and Psychiatry*. 1989;52:18-22
16. Nordvik I, Myhr KM, Nyland H, Bjerve KS, et. al. Effect of dietary advice and n-3 supplementation in newly diagnosed MS patients. *Acta Neurol Scand*. 2000; 102: 143-149
17. Fasano A, Shea-Donohue T. Mechanisms of disease: the roll of intestinal barrier function in the pathogenesis of gastrointestinal autoimmune disease. *Nat Clin Pract Gastroenterol Hepatol*. 2005; 2(9): 416-422
18. Fasano A, Berti I, Gerarduzzi T, Not T, et. al. Prevalence of celiac disease in at risk and not at risk groups in the United States. *Arch Intern Med*. 2003;163:286-292
19. Nicoletti A, Patti F, Lo Fermo S, Sciacca A, et. al. Frequency of celiac disease is not increased among multiple sclerosis patients. *Mult Scler*. 2008 Jun; 14(5):698-700

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RESEARCH HIGHLIGHTS: Autoimmune Diseases and Nutrition/Health

By Kathleen Pellechia, RD

Celiac disease as a possible cause for low serum ferritin in patients with restless legs syndrome. Manchanda et al. *Sleep Med.* 2009 Aug;10(7):763-5

Article Summary: The authors' intent was to present four cases of restless legs syndrome (RLS) in which undiagnosed celiac disease (CD) was found to be a likely cause for low serum ferritin. The diagnosis of RLS was conducted through face-to-face clinical interview. Following positive serologic screening for CD, diagnosis was confirmed based on small bowel biopsy and response to a gluten-free diet. RLS symptoms improved in all four patients; RLS medication was discontinued in two of the patients. Low-iron stores have been found to be a risk factor for RLS; the authors suggest additional testing for CD as diagnosis and subsequent treatment of CD may improve the health of individuals with RLS.

Long-term moderate intervention with n-3 long-chain PUFA-supplemented dairy products: effects on pathophysiological biomarkers in patients with rheumatoid arthritis. Dawczynski et al. *Br J Nutr.* 2009 May;101(10):1517-26

Article Summary: The focus of this study was the effect of n-3 LC-PUFA-supplemented dairy products on inflammation and immunological parameters, biomarkers of oxidative stress, serum lipids, and disease activity in patients with rheumatoid arthritis (RA). Forty-five subjects (forty-three females and two males) were randomly divided into two groups in a double-blind, placebo-controlled cross-over study. Both groups received placebo or verum products consecutively for 3 months with a 2-month washout phase between the two periods. Blood samples were taken at the beginning and at the end of each period. The following criteria were assessed both at the beginning and at the end of each period: body weight; blood pressure; duration of morning stiffness as estimated by the patients; and the disease activity score. Patients had to fill a nutrition diary in both study periods, where they documented the daily consumption (kind and amount) of meat, meat products, fish, fish products, oils and fats.

The dairy products generally improved serum lipids by increasing HDL and lowering lipoprotein a. In addition n-3 LC-PUFA suppressed the immune response as lymphocytes and monocytes were found to be significantly decreased. Disease activity or inflammatory markers were not affected although other studies have previously shown potential benefits of this therapy. However long-term intake of dairy products can protect cartilage and bone health and it was found that the intake of the n-3 LC-PUFA did not cause oxidative injury, lipid peroxidation or DNA damage.

Oral Health Needs Among Adults in the United States With Chronic Diseases. Griffin et al. *J Am Dent Assoc.* 2009; 140:1266-1274

Article Summary: Using NHANES data, Griffin et al. aimed

to determine the prevalence of untreated dental diseases, self-reported poor oral health and the number of missing teeth for adults in the United States who had certain chronic diseases. The authors used multivariate analysis to determine whether these diseases were associated with indicators of dental disease after controlling for common risk factors. Five indicators of dental disease were used in the study: caries, periodontal disease, any other dental/oral problem (such as gingivitis, soft tissue damage, etc.), missing teeth and self-reported oral health. Results of the study indicated that participants with rheumatoid arthritis, diabetes or a liver condition were twice as likely to have an urgent need for dental treatment as were participants who did not have these diseases. Logistic regression was used to examine whether the indicators varied among adults depending on the presence of chronic disease. After controlling for common risk factors, the authors found that arthritis, cardiovascular disease, diabetes, emphysema, hepatitis C virus, obesity and stroke still were associated with dental disease. This association held in the multivariate analysis, suggesting that some chronic diseases may increase the risk of developing dental disease, decrease utilization of dental care or both. Future studies in this area as well as examining the impact of poor dental health on risk of developing chronic disease are needed.

Potential Dietary Links to Central Sensitization in Fibromyalgia: Past Reports and Future Directions. Holton et al. *Rheum Dis Clin North Am.* 2009 May; 35(2): 409-20

Article Summary: The authors identified 9 articles containing original data that also included subjects with a diagnosis of Fibromyalgia (FM) that meets standardized criteria. In addition the examined studies included whole food interventions versus dietary supplements. Studies in this area have so far looked at vegetarian diets, weight loss, or elimination diets as potential treatment mechanisms. The authors identified studies in these areas however also came across studies that involved the removal of specific dietary components which may act as triggers. Glutamate (in the form of MSG) and aspartate (in the form of aspartame) are two such substances. The authors found only one study in the review that identified drug therapy as a superior treatment over dietary therapy. Limitations to dietary therapy such as study participants not typically continuing the dietary treatment past the study period were noted as well. Future studies that look at dietary intervention in patients with FM are needed as well as studies that look at dietary treatment of other common FM comorbidities (IBS, migraines, etc.). These comorbidities also involve central sensitization (increased response to stimulation and pain) thus the use of dietary intervention for those conditions may help in the treatment of FM.

Source: PubMed.gov-U.S. National Library of Medicine, National Institutes of Health

UNITED STATES BREASTFEEDING COMMITTEE (USBC) *January 2010 Meeting*

Opportunities for Collaboration:

1. The ADA, along with its strategic partners, has begun to advocate for the reauthorization of the Child Nutrition Act. ADA welcomes collaboration with other member organizations to ensure timely passing of the reauthorization this spring. Organizations interested in working together to support this legislation which authorizes the Women, Infant, and Children's (WIC) Program are encouraged to contact Jennifer Teters, Congressional and Political Affairs Manager at jteters@eatright.org.

2. The ADA Evidence Analysis Library is available for use by health care professionals. The breastfeeding topic includes a review of the evidence for three key questions. The topic can be viewed at www.adaevidencelibrary.com. There is a subscription fee to non-members, however, ADA members can access the site at no cost.

Highlights of activities related to the mission of USBC (since the last meeting):

- In November, the updated "Position of the American Dietetic Association: promoting and supporting breastfeeding" was published which reaffirmed the Association's position that breastfeeding is the preferred form of infant feeding (J Am Diet Assoc. 2009 Dec;109:(12)1979). This position paper utilized information available in ADA's Evidence Analysis Library which addressed three specific breastfeeding questions and provided science-based answers with strength of evidence. Copies of the paper are available at the USBC meeting or on the ADA website (www.eatright.org).

- At the Food and Nutrition Conference and Exposition, ADA once again offered a "Mother's Room" sponsored by the Public Health and Community Nutrition Dietetic Practice Group and assisted by the Women's Health Dietetic Practice Group. Approximately 34 members utilized the room with nearly 100 visits. The room was used by members, staff, speakers and others who were in attendance. The ADA provided eight nursing rooms with chairs and tables along with refreshments. Student volunteers from ADA's Student Host Program volunteered to staff the room along with credentialed dietitians and helped to collect data and maintain the rooms. This was the sixth year that the room has been offered.

- The Women's Health Dietetic Practice Group offered members the opportunity to learn more about breastfeeding via its newsletter and teleconference program. The fall issue of the Women's Health Report offered a case study, "Breastfeeding and Celiac Disease: A Case Study and Review" by Julie Harker Buck, MHE, RD, CD, LCCE. This issue of the Report focused on Celiac Disease. A teleseminar was also conducted in September 2009 by the practice group titled "Bariatric Surgery: Implications for Nutrition During Pregnancy and Lactation." This event was presented by ADA Member Representative to the USBC, Jeanne Blankenship, MS RD CLE who is a national speaker and expert in bariatric surgery nutrition and women's health.

Other activities or details:

- ADA recently launched an updated website with new information and resources designed specifically for health care profession-

als. Resources include access to position papers, nutrition information, and links to ADA alliances including the USBC. The site also has a section that targets the general public. Visit the website at www.eatright.org.

- ADA continues to maintain network relationships with International Lactation Consultant Association (ILCA) and the International Board of Lactation Consultant Examiners (IBLCE).

- The Women's Health Dietetic Practice Group is now linked to "Feeding Your Baby: What Parents Should Know Regarding H1N1." This practice group and the ADA website (www.eatright.org) both have links to the USBC.

- There were three articles published in the Journal of the American Dietetic Association since the last USBC meeting which included the aforementioned position paper and two additional articles:

- Wijndaale K et al. Determinants of early weaning and use of unmodified cow's milk in infants: a systematic review. J Am Diet Assoc. 2009 Dec;109(12)1979.

- Cahill, JM et al. Development and validation of the stimulus index in low-income, minority women in early postpartum. J Am Diet Assoc. 2009 Sep;109(9):1593.

- On-line Public Policy Workshop will begin Monday, March 22, 2010 with kickoff parties being planned by each state.

- The annual Food and Nutrition Conference and Exposition is scheduled for November 6 – 9, 2010 in Boston, Massachusetts.

Looking to Get Involved?

We are currently recruiting for the following positions:

**Mentoring Coordinator, Research Coordinator
Lactation Section Editor, Perinatal Section Editor,
Weight Section Editor, Women's Health Section Editor,
and Publication Assistant.**

For more information, please contact
whdpgcommunications@gmail.com

our mission

*"Leading the future of
dietetics in women's health."*

MEMBER SPOTLIGHT *By Stefanie Casillas*



Elizabeth Ward, MS, RD

*An active contributing member who recently hosted the teleconference, "Update on the Institute of Medicine's Pregnancy Weight Gain Guidelines," Elizabeth Ward is the author of several nutrition titles. Her work includes **Expect The Best: Your Complete Guide to Healthy Eating Before, During, and After Pregnancy;***

***The Pocket Idiot's Guide to the New Food Pyramids; The Complete Idiot's Guide to Feeding Your Baby and Toddler; Healthy Foods, Healthy Kids: A Complete Guide to Nutrition for Children from Birth to Six Years Old, and Pregnancy Nutrition: Good Health for You and Your Baby.** Elizabeth Ward was an ADA spokeswoman from 1992 to 2002, and contributes to publications such as *Men's Fitness* and *Fit Pregnancy*. She lives with her husband and three daughters. It is our pleasure to spotlight Elizabeth Ward in this issue.*

How did you get into dietetics?

I was into sports in high school and my father was into physical fitness as well, so I became interested in diet and healthy eating to improve my athletic ability. Nutrition was up and coming at the time as well. For these reasons I decided to study nutrition and dietetics when I went to college.

Tell us about your career path as an RD; where have you worked? What was your first job?

After graduating from the University of Massachusetts at Amherst I completed my dietetic internship at Brigham and Women's Hospital in Boston. I had two jobs when I first started my career as a dietitian: one at Salem hospital and the other at Medical Care Affiliates, a medical

office that also did health promotion at companies. At the latter job I counseled patients at the office and also did health promotion at companies, teaching weight loss and prevention classes. This was my first experience educating others on nutrition.

What made you get more involved in women's health?

I became interested in women's health and pregnancy when I worked with pregnant women at the Harvard Community Health Plan. Then, I became even more interested in this specialty when I started having children. Once you've lived through it yourself, it's easier to be interested. You have to think about how people live and then put the guidelines and recommendations into language that they can understand.

What do you consider a highlight of your career?

Being on the Today Show in August 2009. Also, being the ADA spokesperson from 1992 to 2002; it was a great experience.

What resources do you find most helpful in your daily work?

I read a lot! I read www.medpagetoday.com, the table of contents of both the Journal of the American Academy of Pediatrics and the Journal of Pediatrics, Obstetrics and Gynecology. I also like the American Journal of Clinical Nutrition and rely heavily on the Institute of Medicine. If I don't know the answer to a question, I'll use the Internet and these resources to find the answer.

THANK YOU LETTER *From the American Dietetic Association*

Dear Denise and Women's Health DPG members:

On behalf of the American Dietetic Association, we want to thank the DPG for all the time and effort assisting in the review of the ADA position, "Nutrient Supplementation," published in the December *Journal of the American Dietetic Association*. As experts in your area of practice, we realize that the practice group is frequently requested to share knowledge and expertise. We are especially grateful that Diane Whelan was willing to accept this additional responsibility for the Association and the dietetics practice group.

A thorough and careful review is critical to the position development process which results in an accurate, credible, and up-to-date position. For your information, if the comment/s you provided were not addressed in the published paper, the authors have provided a collective response (attached) to comments provided from all reviewers involved in the review process.

We are very proud of the final position and extend our congratulations and appreciation for your contribution to this position and the Association.

Sincerely,

Jessie Pavlinac, MS, RD, CSR, LD, President

Ethan Bergman, PhD, RD, CD, FADA, Speaker, House of Delegates

IS NATION'S OBESITY RATE SLOWING? AMERICAN DIETETIC ASSOCIATION URGES KEEPING HEALTHY LIFESTYLE

CHICAGO – In light of a study in the January 20 issue of the Journal of the American Medical Association suggesting the rate of increasing obesity in America may have slowed over recent decades, the American Dietetic Association reminds everyone that obesity prevention through a healthy lifestyle remains an important public health priority.

“Encouraging signs are always welcome when it comes to reducing the national obesity epidemic,” said registered dietitian and ADA President Jessie M. Pavlinac. “It will be a great day when we can confirm that Americans are making significant progress in achieving a healthy weight, especially among children.

“More research therefore will be needed to confirm these findings,” Pavlinac said. “The American Dietetic Association and our members remain committed to reducing the physical and economic costs of obesity and obesity-related health problems in our country by providing expert guidance to consumers that is personalized, doable and affordable.”

The study states obesity estimates “for the period 2003-2004, 2005-2006, and 2007-2008 did not differ significantly from each other. These data suggest that the increases in the prevalence of obesity previously observed between 1976-1980 and 1988-1994 and between 1988-1994 and 1999-2000 may not be continuing at a similar level over the period 1999-2008, particularly for women but possibly for men.”

“While this analysis shows a slowing of those Americans developing obesity, it is also true that the most rapidly growing population category is Americans who are becoming severely obese. It is, therefore, extremely

important we continue to learn everything we can to understand this disease along with the most effective treatments,” Pavlinac said.

Another study in the January 20 JAMA found the prevalence of high body mass index among children and teens in the U.S. has remained steady over the past 10 years.

“These numbers indicate the continued focus our country must place on raising healthy children,” Pavlinac said. “The link between childhood obesity and adult obesity is very strong, so it is extremely important that we as parents provide our children with the tools they need to develop and maintain healthy eating plans.”

The American Dietetic Association Foundation has developed the Healthy Schools Partnership program, designed to develop long-term solutions to the youth obesity epidemic. The program places registered dietitians in schools as “RD Nutrition Coaches,” working with physical education coaches to help children change eating behaviors with short, one-on-one sessions while being physically active. For more information on the program, visit www.eatright.org/foundation.

The American Dietetic Association is the world’s largest organization of food and nutrition professionals. ADA is committed to improving the nation’s health and advancing the profession of dietetics through research, education and advocacy. Visit the American Dietetic Association at www.eatright.org.

FNCE’s Mother’s Room

This past year’s Food & Nutrition Conference & Expo (FNCE) in Denver, CO once again offered a “Mother’s Room” with the assistance of members from the WH DPG and the Public Health and Community Dietetic Practice Group. A recent report counted the following:

Number of Mothers who used Mothers Room at FNCE2009 = 34 mothers

Number of Visits = >96 visits

Comments:

“Just wanted to let you know that we had huge support from ADA.”

“They created us eight nursing/breastfeeding rooms w/nice and comfortable chairs and tables.”

“Student volunteers from ADA Student Host Program did a great job”

Thank you to all you volunteered their time to making this possible!

WH LEADERSHIP CONTACT INFORMATION

Executive Committee

Chair

Denise Andersen, MS, RD, LD
whdpgchair@gmail.com

Chair-Elect

Stephanie Bess, MS, RD, CDN, CLC
whdpgchairelect@gmail.com

Past Chair

Jamillah Hoy-Rosas, MPH, RD, CDN, CDE
whdpgpastchair@gmail.com

Secretary

Diane Whelan, MPH, RD
whdpgsecretary@gmail.com

Treasurer

Judy Simon, MS, RD, CD, CHES
whdpgtreasurer@gmail.com

Key DPG Contacts

Membership Committee Chair

Maria Pari-Keener, MS, RD, CDN, CPT-NASM
whdpgmembership@gmail.com

Retention/Recruitment Coordinator

Shoshana Weber, MS, RD

Communications Chair

Miri Rotkovitz, MA, RD
whdpgcommunications@gmail.com

Publications Editor

Olivia Eisner, MPH, RD, IBCLC
whdpgpublications@gmail.com

Assistant Publications Editor

Nancy Turnier, MS, RD

Lactation Section Editor

Julie Harker Buck, MHE, RD, CD, LCCE

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whdpgnominations@gmail.com

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whdpgpublicpolicy@gmail.com

Research Coordinator

Megan Tubman, MS, RD
whdpgresearch@gmail.com

Web site Coordinator

Kathleen Pellechia, RD
info@womenshealthdpg.org

Listserv Coordinator

Lisa Hamlett Akers, MS, RD, IBCLC, RLC
wrnsc@yahoo.com

DPG/MIG/Affiliate Relations Manager

Karen Jaseckas, RD, LDN
KJaseckas@eatright.org

WHAT IS QUALITY DIETETICS? DO RDS PRACTICE IT? HOW DO DIETETICS PRACTITIONERS KNOW THE ACTIVITIES THEY ARE AUTHORIZED TO PERFORM?

Quality is about providing safe, effective, patient/resident/client-centered, timely, efficient, and equitable dietetics care. These six dimensions of quality are outlined in a report by the committee on the Quality of Health Care in America (1). Overall, the report makes an urgent call for fundamental change to close the quality gap, recommends a redesign of the American health care system, and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. The report urges these health care constituencies to commit to a national statement of purpose for the health care system as a whole. In making this commitment, the parties would accept as their explicit purpose “to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States (1).

What steps must be taken to provide quality dietetics care?

RDs in all practice settings must review and understand federal and state regulations, accreditation standards (if applicable to their facility or service), their facility policies and procedures, and their individual scope of practice. RDs must read the regulations and interpretive guidelines of the Centers for Medicare & Medicaid Services (CMS) - Conditions of Participation for their respective practice setting. RDs must know the federal and state licensure requirements for food and dietetics service personnel, the food and dietetics service standards, laws and regulations, and their state practice acts to locate what, if any, legal scope of practice is defined within the state where they are employed.

RDs must also note their accreditation standards (if applicable) that their facility or practice setting utilizes to ensure they are providing quality care. These accreditation standards are aligned with the CMS Services - Conditions of Participation and its regulations for food and dietetic services. Accreditation organizations are: The Joint Commission, Healthcare Facilities Accreditation Program of the American Osteopathic Association, DNV-National Integrated Accreditation for Healthcare Organizations, and Public Health Accreditation Board.

Next, RDs must know their facility policies and procedures in order to perform effectively within medical executive approved disease and condition specific protocols that outline standing nutrition orders. RDs must determine and approve, along with the Medical Executive Director or Board, their formulary of therapeutic diet orders for the patients/residents/clients under their nutrition care. RDs who demonstrate competency at the advanced practice level may then apply to obtain clinical privileging in their facilities to perform medical level tasks.

How do RDs know that they are able to apply for privileges within their facility?

According to CMS, clinical privileging “is a process by which the governance of the hospital- specifically the governing body and the medical staff- develop and implement a process to ensure safe and quality patient care” (2). Practitioners, including RDs, must demonstrate competence of medical level tasks (e.g., ordering therapeutic diets, ordering parenteral nutrition) to obtain and maintain clinical privileges. Obtaining clinical privileges for RDs depends on the RD’s legal scope of practice, medical staff bylaws in the facility, culture of the facility, and the RD’s competency level (2).

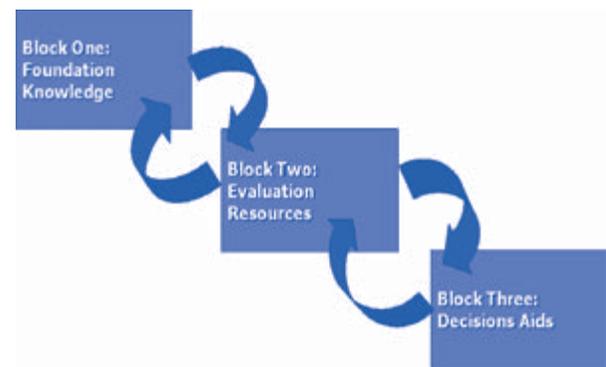
How is scope of practice defined?

Scope of practice is defined by The University of California at San Francisco’s Center for the Health Professions as: “legal scopes of practice for the health care professions establish which professionals may provide which health care services, in which settings, and under which guidelines or parameters. With a few exceptions, determining scopes of practice is a state-based activity. State legislatures consider and pass practice acts, which are referred to as statute, law, or code. State regulatory agencies, such as medical or other health professions’ boards, implement laws by writing and enforcing rules and regulations detailing the acts” (3).

Each RD must know his/her individual scope of practice and should be performing at his/her highest level to provide best quality care. How does an RD determine this level? By using the ADA Scope of Dietetics Practice Framework to determine his/her own individual scope of practice and verify if he/she is qualified to do what he/she has been hired to do. What competencies has the RD obtained? Does the RD accept responsibility and accountability for his/her own nutrition care actions? Bottom-line --- **Quality begins with Competency.**

The ADA Scope of Dietetics Practice Framework is designed to assist the RD with determining whether a service is within his/her own scope of practice. RDs will not find a laundry list of services and skills a dietetics practitioner can do. Lists tend to limit practice. Scope of practice is a fluid concept. It changes as knowledge, the healthcare environment, and technology expand. Dietetics practitioners must possess the knowledge, skills, and competencies to perform their duties; therefore, scope of practice comes down to the competency of the individual dietetics practitioner and his/her particular practice setting (4).

The Framework is divided into three blocks: foundation knowledge, evaluation resources, and decision aids.



Block Two – Evaluation Resources – comprises the Standards of Practice (SOP) in Nutrition Care and Standards of Professional Performance (SOPP) for RDs and DTRs which are a guide for self-evaluation (5). The SOP in Nutrition Care and SOPP for RDs and DTRs are minimum competent levels for RDs and DTRs in all practice settings. Practice specific SOP and SOPP identify generalist, specialty, and advanced levels of practice within a particular practice area (e.g., education, pediatrics, management, sports dietetics, etc). RDs and DTRs can use the SOP and SOPP to determine their individual competency level, determine areas where skills need to be developed, and devise a professional development plan to advance their level of practice.

RDs must provide evidence-based, quality dietetics practice. An RD’s practice must be measured, documented, and reported as part of their performance improvement program to verify quality services and demonstrate value through outcome, process, and structural measures. How involved are RDs in their quality team or quality and safety committee at their facility or practice setting? Quality is not going away – it is being taken to the next level as demonstrated in our future federal and state health care reform (6). Be prepared to measure your performance, be patient/resident/client-centered driven! RDs must decide on how to be included in measurement, as measurement will predict quality and quality will receive compensation for nutrition care services. **Do It Right the First Time: Quality Dietetics Practice is the RD and DTR.**

This article was written by Sharon M. McCauley, MS, MBA, RD, LDN, FADA, director of Quality Management at ADA in Chicago, IL, and Cecily Byrne, MS, RD, LDN, manager of Quality Management at ADA in Chicago, IL.

Diane Whelan, MPH, RD
15315 Magnolia Boulevard, Suite 415
Sherman Oaks, CA 91403

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GOALS OF THE WH PRACTICE GROUP

WH DPG promotes the development of dietetics professionals in the specialty area of nutritional care in women's health which includes preconception through pregnancy and lactation and expanded to late menopause.

The objectives of the Women's Health DPG are:

1. Build an aligned, engaged and diverse membership.
2. Proactively focus on emerging areas of women's health.
3. Impact the research agenda in women's health and nutrition.
4. Identify and influence key food, nutrition and health initiatives specific to women.
5. Increase demand, utilization and reimbursement of services provided by WH members.

"WH members are the most valued source of nutrition expertise in women's health"